An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 149

Year: 2024

Inspection Report

Year:	**2024**
Name of Organisation:	**24Hr Care Services Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**9th & 10th October 2024**
Registration Status:	**Registered from 14th March 2022 to 14th March 2025**
Inspection Team:	**Mark McGuire** **Catherine Hanly**
Date Report Issued:	**23rd December 2024**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.

The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined. During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 14th of March 2019. At the time of this inspection the centre was in its second registration and was in year three of the cycle. The centre was registered without attached conditions from 14th March 2022 to 14th March 2025.

The centre is registered as a multi-occupancy service, providing medium- to long-term care for up to four young people, aged 13 to 17 at the time of admission. The centre's aim is to deliver trauma-informed care, promoting positive outcomes through education and fostering strong family connections. According to its statement of purpose, the centre seeks to build trusting, cooperative relationships with young people, while identifying and nurturing their strengths and resilience. At the time of inspection, four young people were residing in the centre.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.2
3: Safe Care and Support	3.1
8: Use of Information	8.2

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 21st of November 2024. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The director of services returned the report with a CAPA on the 5th of December 2024. This was deemed not to be satisfactory and an updated CAPA was received by the inspection service, following some clarifications completed with the management team, on the 16th of December 2024. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 149 without attached conditions from the 14th March 2022 to the 14th March 2025 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 7: Staffing

Theme 2: Effective Care and Support

Standard 2.2 Each child receives care and support based on their individual needs in order to maximise their personal development.

Inspectors found that three out of four young people had up-to-date care plans on file, while delays were noted in obtaining some documentation in the past. Social workers attributed these delays to staff resourcing issues in the social work department. However, the centre had maintained its own minutes during these gaps, and inspectors observed evidence of requests and escalations made by centre management to address the delays. There were also some gaps identified in the timelines for child-in-care reviews (CICRs). A new resident had recently been admitted, and their CICR was scheduled. Inspectors observed the involvement of multiple professionals at CICR's, with schools and specialists being invited to participate where relevant. In instances where family members faced difficulties attending, social workers made efforts to accommodate their input.

It was evident to inspectors that the care team tried to encourage young people to participate in their CICR's and where they refused to attend or did not wish to engage, the team endeavoured to capture their voice through 'Me and My CICR' forms or through individual work sessions. The care team then advocated when required for young people and one staff member outlined examples of this process to inspectors during their interview as part of the inspection process.

The centre used the title placement support plan (PSP) for their placement plans. Each young person had a PSP that was linked to their care plan and was regularly updated outlining clearly both their short-term and long-term goals. Inspectors found these documents were easy to follow, with clear identification of those responsible for key work tasks and goal follow-up. The PSPs also included corresponding key work report numbers for completed work making it easy to track the details of progress being made for young people. However, inspectors noted that more emphasis could have been placed on independent living skills for the two young people nearing the age of eighteen. A renewed focus on aftercare preparation and planning was recommended by inspectors for both individuals. One young person did

not have an aftercare plan, while the other young persons was still in draft form, and staff were unclear about the aftercare arrangements during interviews. Despite this, inspectors reviewed the draft aftercare document and met with the young person who it referred to. This young person spoke of how they had been included in the drafting of this document and that their wishes and preferences for education had been taken into account, leading to the need to redraft the plan.

The PSPs had sections to indicate that young people were consulted, along with their families when appropriate, though inspectors found that these sections would benefit from more detailed content that captured the young people's direct contributions. While individual goals were clearly identified and regularly reviewed, inspectors found that for one young person, their progress and challenges relating to specialist supports wasn't clearly tracked in the process. Overall, inspectors found the PSP document format to be comprehensive and easy to follow, though issues with sequencing care plan and child protection and welfare report forms (CPWRFs) at the back of the document were noted, which will be addressed later in this report.

Young people in placement were supported to access relevant specialist services in most cases. Where disengagement occurred, social workers were actively involved in sourcing alternative options. Inspectors found that more attention could be given to the needs of one young person in this regard, particularly concerning their dysregulation, given ongoing concerns and the required implementation of a 2:1 staff ratio to safely manage their behaviours of concern. All parties involved with this young person felt that while they were making progress in many areas, their underlying difficulties required specialist support to facilitate further development. While they had been facilitated previously to attend a specialist support service, this had recently come to an end and inspectors suggest that the assessment of need and sourcing of specialist support is kept under review by the various professionals involved. Social workers interviewed also praised the staff's care and commitment to supporting young people, especially when challenges arose, noting the persistence and encouragement shown by the team even when young people were reluctant to engage. Progress was also observed by inspectors for all the young people in various aspects of their placements at the centre such as their educational goals.

All social workers interviewed confirmed that they received prompt notifications of incidents through the significant event notification (SEN) system. However, one social worker, allocated to the most recently admitted young person, expressed uncertainty about the expected frequency of updates, noting that this would be formalised at the upcoming CICR. Centre management later informed inspectors that

these timelines had already been discussed during a pre-admission meeting and had been formalised at the recent CICR. Another social worker acknowledged positive communication overall but was unaware of the 2:1 staffing ratio or the associated risk of allegations made by one young person against male residents.

One social worker highlighted communication difficulties that arose during their unexpected leave, which had been formally acknowledged through complaints submitted by centre staff and their allocated young person via the complaints channel and Tusla's Tell Us process. The social worker explained that plans were in place to address the issue with support from their social work team leader, and the centre team expressed a willingness to engage in this process. However, this social worker was not initially included in a review of the 2:1 staffing ratio and associated control measures for their allocated young person. Centre management responded proactively when inspectors raised this concern and conducted a review and update of the safety plan with social work involvement. Social workers must be regularly updated on emerging risks affecting their allocated young person and be consulted on such matters to ensure effective collaboration.

Inspectors found deficits in staffing levels to meet the young people's needs. Centre and senior management informed inspectors of ongoing recruitment efforts and the challenges they have faced in this regard. None of the social workers interviewed were aware of the need for agency staff to support the 2:1 staffing ratio. While the centre met the minimum regulatory requirements outlined in the ACIMS Regulatory Notice - Minimal Staffing Level & Qualifications CRC Settings (August 2024), inspectors found that the core team had not increased to accommodate the individual needs of four young people, including one requiring a 2:1 staffing ratio. There was a heavy reliance on agency personnel, and one member of the core team did not meet the minimum qualification requirements specified in the regulatory notice. The centre must ensure that this staff member's duties are adjusted to comply with these regulatory requirements.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 7**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required	**Standard 2.2**

standard in some respects only	
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- Centre management must improve aftercare preparation and planning for young people nearing the age of 18.
- Centre management must ensure the PSPs include more detailed input from young people and their families.
- Centre management must ensure regular communication and collaboration with social workers regarding emerging risks, staffing ratios, and changes to risk control measures.
- Centre and senior management must ensure that staff members who do not meet minimum qualifications have their duties adjusted to comply with regulatory requirements.

Regulation 5: Care Practices and Operational Policies

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

Inspectors found that the centre had a comprehensive child safeguarding policy and practices document, which largely aligned with the requirements outlined in the Children First Act 2015. This policy detailed procedures for responding to and reporting child protection or welfare concerns, as well as the roles and responsibilities of the designated liaison person (DLP). It also outlined the categories and indicators of abuse, the process for reporting allegations against staff, and other related matters.

Inspectors found that while the centre had clear policy guidance on identifying and responding to abuse, gaps in practice were evident, particularly in addressing child sexual exploitation (CSE) risks and involving An Garda Síochána (AGS) in serious concerns related to content found on a mobile device. Centre management had received CSE training and informed inspectors during interviews that CSE risks were to be discussed and documented in collaboration with social workers through the formal CSE reporting channel. However, inspectors identified one case where this

process was not followed. The social worker for the young person involved stated that the CSE concern had not been brought to their attention for discussion, nor was the need to alert AGS regarding the mobile device directly addressed. Inspectors did note evidence of the original concern being submitted to social work as a CPWRF and through the Tusla SEN portal. Centre management must ensure that all CSE concerns are addressed appropriately, including consultation with relevant social workers and the use of the CSE1 reporting form.

In the incident involving the mobile device, this should have been immediately reported to AGS and handed over to them. Centre management assured inspectors that the device had been securely stored with limited access and that AGS had since advised they would collect it during a consultation with the young person. However, inspectors recommend that in the future, incidents of such seriousness be reported and handed over to AGS without delay.

Clear policies were in place on safe recruitment, vetting, managing allegations against staff, and anti-bullying. However, the policies did not outline those assigned as mandated persons, nor the roles of staff who were not mandated persons with regards to child protection, and there was inconsistency regarding the Designated Liaison Person (DLP), as one policy named a different individual than the Child Safeguarding Statement (CSS). Staff interviewed, were however clear on who the DLP and Deputy DLP's (DDLP) were and consulted with them for support and guidance, where required, on child protection matters.

The CSS was prominently displayed in the centre and signed by the relevant individuals and inspectors were provided with a letter of compliance also from the Tusla Child Safeguarding Statement Compliance Unit. The CSS clearly outlined the names and contact details of the DLP and DDLP and included the assessed risks for young people availing of the service, along with the policies and procedures in place for managing these risks. Inspectors found that risks related to CSE were not explicitly identified in the CSS, nor were the procedures for managing them. As part of its legal obligations under the Children First Act, 2015, the centre must conduct a risk assessment for all areas where children may be exposed to harm. Given the prevalence of CSE concerns noted during the inspection, centre management must include the risk of CSE in their CSS going forward.

While inspectors found that, for the most part, child protection concerns were promptly and appropriately notified through the Tusla portal, they observed a tendency to 'over-report' concerns that would not meet the threshold of significant

harm, leading to unnecessary duplication of records. One social worker interviewed noted that, as a result, many of these reports were closed immediately at the screening stage. During interviews, inspectors found that the care team was aware of their mandated reporting roles and familiar with the Tusla portal for making such reports, though inspectors were also informed of a centre-wide approach to 'report everything'. While inspectors recognized the good intentions behind this practice, it does not align with the process of assessing reporting thresholds as outlined in *Children First: National Guidance for the Protection and Welfare of Children* (2017). Inspectors brought this issue to the attention of centre and senior management, recommending refresher training on child protection procedures. In response, centre and senior management proactively sought external training from a child protection specialist, demonstrating their commitment to addressing inspection findings and improving child protection practices. Inspectors also observed that parents/guardians were informed of incidents, where appropriate, and noted a list of relevant contacts on each young person's care file.

The centre had an anti-bullying policy that staff referred to during interviews conducted as part of the inspection. The policy outlines clear examples of bullying, methods for identifying bullying, procedures for addressing incidents, processes for recording bullying incidents, and the centre's overall zero-tolerance approach. Inspectors found that although staff could reference the policy, they did not demonstrate in-depth knowledge of these procedures. The care team reported that there were no current bullying incidents in the centre and described how they would use mediation and implement safety plans if needed. However, inspectors recommend that the policy be reviewed with the care team to ensure familiarity with the outlined examples, identification methods, and the recording and reporting processes.

Individual areas of vulnerability were identified and addressed through key working sessions, safety plans, risk assessments, and 'care approach' documents that outlined how the team would support young people in managing these vulnerabilities. Inspectors reviewed these documents and found that the care approach and safety plan for a procedure requiring 2:1 staffing for one young person lacked sufficient detail on response measures to safeguard other young people at risk of false allegations. The emphasis on risks associated with staff interactions overshadowed those related to peer-to-peer dynamics, which contributed to continued peer-to-peer incidents without a formal review of the existing safety plan. Additionally, inspectors found that the risk ratings in the centre's risk register required review, as one risk was rated as low despite the high-risk safety plan and 2:1 staffing response in place.

Inspectors raised these concerns with centre and senior management, who responded proactively post-inspection by scheduling a review meeting with the young person's allocated social worker and implementing a more robust safety plan to address the identified gaps. Inspectors also reviewed key working documents, finding them to be supportive and well-focused on helping young people develop knowledge and self-awareness skills around their vulnerabilities. Additionally, inspectors observed young people voicing concerns about feeling unsafe in certain areas, which reflected the trusting relationships they had established with the care team.

Inspectors reviewed staff training records and found that all care team members had completed the Introduction to Children First E-Learning module, which senior management indicated is mandatory at the start of employment. However, inspectors identified training gaps in areas critical to the centre's risk profile, specifically for mandated persons and self-harm, despite self-harm being an identified risk within the centre. Additionally, while management had completed CSE training, not all of the care team members had completed this training too, though this was an ongoing concern in the centre. Training for suicide/self-harm, mandated persons, and CSE must be completed by the entire care team to ensure they are fully equipped to meet the young people's safeguarding needs. During the inspection, the centre manager addressed the team, requiring them to complete the mandated persons training without delay. It is important that the remaining training gaps relating to CSE, suicide/self-harm and mandated persons training are also addressed.

Inspectors found that the centre's child protection register was not fully aligned with PSP summaries of SENs, which hindered effective tracking of incidents. The log also lacked details on efforts to resolve open cases, with at least 55 child protection reports still open with no conclusion reached, some dating back to March 2024. Additionally, the 'note on file' column was underutilised for tracking progress, and there was no documentation in the log to show how centre and senior management had queried the resolution or status of these cases. Inspectors observed some evidence of requests being made to social work in the social work contacts section of the care record, but updates need to be consistently tracked in the centralised child protection log for clarity and ease of access. Inspectors recommend enhancing the recording and oversight of Child Protection and Welfare Report Forms (CPWRFs) in the child protection log and suggest that senior management implement more thorough oversight.

Inspectors found that a protected disclosure policy was in place, referencing an external reporting process through the Health Service Executive (HSE) which is

outdated advice and must be reviewed and updated. The policy also lacked detail on the internal procedure for disclosures. While staff reported familiarity with the policy and the process for reporting incidents, inspectors noted a past incident where staff did not follow the policy, raising a concern with management only after a delay. Inspectors observed that this issue was subsequently addressed with the relevant employee and discussed with the care team in a team meeting. Given the time elapsed since this discussion and the addition of new personnel, inspectors recommend reviewing the protected disclosures policy to ensure it accurately reflects the internal procedure, followed by a refresher on its content for the care team.

Inspectors also reviewed the timeline of the incident where the staff member did not follow the above policy, which related to concerns about a past employee that warranted reporting through the child protection portal. While senior management implemented several safeguarding measures at the time of the incident, no formal review had been undertaken to ascertain if further reports were required or to formally close the matter. Several items on the timeline were still categorized as 'ongoing.' Inspectors recommend a formal review of this incident to ensure that all reportable concerns have been notified and to formally close the matter.

Compliance with Regulation	
Regulation met	**Regulation 5**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- Centre management must ensure that all Child Sexual Exploitation (CSE) concerns are appropriately discussed with social work, with CSE1 reporting forms submitted as needed.
- The relevant person must amend the Child Safeguarding Statement (CSS) to include explicit identification and management of CSE risks, conducting a comprehensive risk assessment in alignment with the *Children First Act, 2015,* requirements.

- Centre and senior management must ensure that concerns notifiable to An Garda Síochána (AGS) are reported without delay.
- The registered proprietor must ensure the service's child protection policy suite is reviewed to address inconsistencies regarding the role of the Designated Liaison Person (DLP).
- Centre and senior management must demonstrate more robust oversight of the child protection log, ensuring all relevant details are captured and sections are used effectively.
- Centre management must review the protected disclosure policy to clarify internal procedures for staff, especially new employees, and provide refresher training to ensure understanding and compliance. Reference to the HSE must also be removed from this policy.
- Senior management must conduct a formal review of the staff investigation to ensure that all reportable concerns have been addressed and to formally close the matter.

Regulation 17: Records

Theme 8: Use of Information

Standard 8.2 Effective arrangements are in place for information governance and records management to deliver child-centred, safe and effective care and support.

Inspectors found that the centre had clear policies on confidentiality, information sharing on a 'need-to-know basis,' data protection and record management. These policies detailed the importance of maintaining case notes, emphasizing that records should be factual, dated, signed, and contemporaneous. They also specified who could access records, and inspectors observed that information was securely stored in compliance with data protection legislation. The team demonstrated familiarity with these policies and procedures for managing sensitive information. However, staff were unclear about the identity of the designated Data Protection Officer (DPO), who did not play an active role in overseeing or auditing records. Following the inspection, the centre manager informed inspectors that they had arranged for the service's DPO to visit the centre to discuss data protection practices with the care team and clarify their role in this area. This proactive response by management highlights their commitment to addressing inspection findings and strengthening data protection practices.

Audits of care files were conducted by a member of the centre's management team; however, inspectors found that the audit process did not identify certain issues noted during the inspection. Specifically, discrepancies were found, such as mismatched child protection and welfare report form (CPWRF) codes across PSPs and the child protection log, as well as documents filed incorrectly within care files. Inspectors also noted that some files were missing from their designated folders, underscoring the need for greater vigilance in record-keeping. Inspectors recommend a review of the audit process to ensure that records are consistently accurate and up to date.

Files were stored securely in the centre, with an additional confidential section for more sensitive information accessible to limited staff. The centre's IT system had various permission levels in place, ensuring secure access to files. Inspectors found that this system provided clarity around file security and were made aware that it was in the process of being further developed to enhance its usability and security further. Care team members had their own work emails and log in details to access the IT system allowing for the tracking and monitoring of usage by personnel.
While the centre's policies outline good practices for information management to ensure that all children's information is protected, respected, and held confidentially, inspectors noted that not all staff had completed GDPR training, as it was not designated a mandatory requirement by the service. GDPR establishes strict guidelines for the collection, use, and storage of personal data, ensuring that individuals' information is safeguarded and maintained confidentially to protect their privacy rights. Following the inspection, centre management instructed all staff via email to complete GDPR training and confirmed that this training would become a mandatory requirement within the service's staff training programme.

Staff were clear on the procedures for sending documents and understood that information should be transmitted through password-protected files using company email systems. Social workers interviewed confirmed that communication from the centre was generally efficient, secure, and prompt. A review of sampled files indicated that relevant notifications were sent in a timely manner, and the care team was clear with inspectors about who they could share personal information with.

Inspectors reviewed the admissions and discharge register and found it complete, with all necessary admission and discharge details accurately recorded and maintained by the centre manager. A separate register was also maintained for archived files returned to Tusla. The centre had a clear policy on the retention and destruction of records, highlighting how files were returned to Tusla as per the directions of their service level agreement, six weeks post-discharge of a young

person. Staff interviewed were familiar with these timelines and the process regarding the return of files to Tusla and the destruction of copies on the service's IT system. However, inspectors found some confusion relating to subject access requests or freedom of information requests that could be made by past residents. They recommend refreshing the data retention policy with the staff team to ensure that everyone is clear that such requests should be directed to the relevant office in Tusla, as the data controller.

The centre had a policy on access to information, and inspectors noted how the team promoted the young people's right to access their records, which was well-documented in the young person's booklet. The policy document and booklet clearly outlined the procedures for children to access a copy of their personal information. One young person who met with inspectors reported that they were aware of their right to access their files and had done so, reflecting the centre's commitment to transparency and the empowerment of the young people in their care.

Compliance with Regulation	
Regulation met	**Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 8.1**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required:

- The centre manager must ensure that all staff are aware of the identity of the designated Data Protection Officer (DPO) and that the DPO plays an active role in overseeing and auditing records.
- The centre manager must review and enhance the audit process to accurately identify discrepancies in case files, including mismatched CPWRF codes and incorrect filing of documents.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
2	Centre management must improve aftercare preparation and planning for young people nearing the age of 18.	Centre management will review after care and the preparation and planning around same at the next team meeting on the 09.01.2025 to ensure improvements in this area.	The director of services will ensure oversight of aftercare and planning for young people as part of the annual auditing review and through their regular centre visits.
	Centre management must ensure the PSPs include more detailed input from young people and their families.	The centre manager, on the 12.12.2024, has changed the box currently within the PSP to ensure it captures a detailed recording of young people and their family's input. This will be shared with the team at the meeting on the 09.01.2025.	The director of services, through a themed audit as part of the annual review and fortnightly PSP reviews, will ensure that the PSP's capture a more detailed account from young people and their families.
	Centre management must ensure regular communication and collaboration with social workers regarding emerging risks, staffing ratios, and changes to risk control measures.	Centre management have spoken to the relevant social work department on the 24.10.2024 to collaborate on the risks referred to here in greater detail. They will ensure continued collaboration with social work regarding such issues going forward.	The director of services, through the annual audit review, will ensure that all communication is shared and evidenced with the social workers to ensure effective collaboration on emerging risks.

	Centre and senior management must ensure that staff members who do not meet minimum qualifications have their duties adjusted to comply with regulatory requirements.	Centre and senior management have immediately adjusted the duties of this staff member in line with regulatory requirements.	The senior management team will ensure that all staff meet the relevant regulatory requirements as part of the recruitment process.
3	Centre management must ensure that all Child Sexual Exploitation (CSE) concerns are appropriately discussed with social work, with CSE1 reporting forms submitted as needed.	A conversation took place with the relevant social worker on the 02.10.2024 in relation to this incident and it was also reported as a CPWRF. Centre management will ensure that going forward they highlight the need also for a CSE1 form to be completed to social work as and when required.	The director of services receives notification of all SEN's and CPWRF's in the centre and will ensure that any Child Sexual Exploitation concerns are discussed with social work and notified collaboratively using the CSE1 form as they arise.
	The relevant person must amend the Child Safeguarding Statement (CSS) to include explicit identification and management of CSE risks, conducting a comprehensive risk assessment in alignment with the *Children First Act, 2015,* requirements.	The senior management team have amended the Child Safeguarding Statement on the 02.12.2024 to include explicit identification and management of CSE risks. CSE had also been assessed within the centre risk register. This will be shared on the 09.01.2024 at the team meeting.	The Director of Services will ensure oversight of the Child Safeguarding Statement as part of the annual review or when required.
	Centre and senior management must ensure that concerns notifiable to An	Centre management will ensure, through their oversight and review of SEN's, that	Senior management receives notifications of SEN's when they occur and will liaise

	Garda Síochána (AGS) are reported without delay.	any required notification to An Garda Siochana will be completed without delay. This incident referred to was reported to AGS and the phone was collected on the 18.11.2024.	with centre management should this issue arise to ensure all concerns are notified immediately and through the correct channels. This will be reviewed also through the annual auditing review.
	The registered proprietor must ensure the service's child protection policy suite is reviewed to address inconsistencies regarding the role of the Designated Liaison Person (DLP).	The registered proprietor has reviewed the child protection policies on the 02.12.2024 to ensure any inconsistencies are amended to clearly identify the role of the Designated Liaison Person and the policy will be distributed to the staff team on the 09.01.2024 at the team meeting.	The Director of Services will ensure oversight and governance of the Child Protection Policy through the annual auditing process and through policy reviews that take when necessary.
	Centre and senior management must demonstrate more robust oversight of the child protection log, ensuring all relevant details are captured and sections are used effectively.	Centre and senior management have completed a review of the child protection log to ensure comprehensive oversight and that all details are correct. Learning from this was discussed at the team meeting on the 31.10.2024 and the 28.11.2024 to ensure consistent recording and that information is inputted into the Child protection log. Robust oversight will be assured through centre managements weekly planning and schedule of tasks	The director of services will ensure oversight and governance of the child protection log through the annual auditing review and through reviews of centre registers as part of their centre visits.

		which focuses on reviewing the centre registers.	
	Centre management must review the protected disclosure policy to clarify internal procedures for staff, especially new employees, and provide refresher training to ensure understanding and compliance. Reference to the HSE must also be removed from this policy.	Senior management updated the protected disclosure policy on the 02.12.2024 to clarify the internal procedures for staff and have removed the HSE from the document. This will be reviewed on the 09.01.2025 at the team meeting to ensure all staff are refreshed on protected disclosures and updated on the policy change.	The director of services will ensure oversight of this policy through the auditing system and ensure that it is a regular calendar item at the team meetings for the staff team.
	Senior management must conduct a formal review of the staff investigation to ensure that all reportable concerns have been addressed and to formally close the matter.	Centre management and senior management completed a formal review on the 24.10.2024 to formally close this matter in full with no further actions required.	Senior management and centre management will ensure going forward that any staff investigation will be formally closed.

8	The centre manager must ensure that all staff are aware of the identity of the designated Data Protection Officer (DPO) and that the DPO plays an active role in overseeing and auditing records.	The senior management team have identified the 23rd of January for our Data Protection Officer to attend a staff meeting to go through our Data Protection policy with the staff team. This will ensure that the staff team are aware of the important role of the DPO within our organisation.	The director of services will ensure that all staff are aware of the DPO and their role within our organisation through interviewing staff as part of theme 8 in the annual auditing schedule. The assignment of the DPO role is also being reviewed by the service and will be completed by quarter two in 2025.
	The centre manager must review and enhance the audit process to accurately identify discrepancies in case files, including mismatched CPWRF codes and incorrect filing of documents.	The centre management team completed a review of case files on 20.11.2024 and have removed the duplication of CPWRF logging in PSP's to avoid confusion in the system and to ensure correct filing of documents. Centre management will also ensure continued auditing of the filing systems as part of their weekly planning and schedule of tasks.	The Director of Services will ensure oversight of case files for discrepancies through the annual auditing process and through reviews of centre files as part of their centre visits. The director of services will also ensure that all learnings are shared at team meetings.